Wight (J.S.)

REPORT OF ONE HUNDRED AND NINE OPERATIONS, PERFORMED AT THE LONG ISLAND COLLEGE HOSPITAL DURING THE REGULAR SESSION OF 1892-3

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REPORT OF ONE HUNDRED AND NINE OPERATIONS, PERFORMED AT THE LONG ISLAND COLLEGE HOSPITAL DURING THE REGULAR SESSION OF 1892–3.

BY J. S. WIGHT, M.D.,

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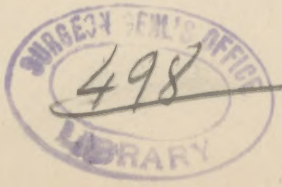
CASE I.—C. B., a sailor, eighteen years of age, was admitted to the hospital, September 16, 1892, on account of disability caused by incomplete descent of the left testicle. When he stood up, the testicle would appear at the external inguinal ring; when he lay down, the testicle went back into the abdominal cavity, where it could not be felt; and when the testicle was in the inguinal canal, it was compressed so as to cause more or less pain. The operation of exsection was performed September 21st: The testicle was brought down; the inguinal canal and the spermatic cord were seized with a pair of forceps; the object was to keep the testicle from disappearing during etherization. An oblique incision over the inguinal canal exposed the spermatic cord and the testicle, which was small and only partially developed. The spermatic cord was transfixed near the internal ring, and ligated in two parts with a strong piece of catgut. The wound was completely closed with deep aseptic silk sutures, which acted as ligatures; then a compress was applied. At the end of a week the sutures were removed, when there was primary union, except a small point near the middle of the line of apposition of the cut surfaces.

CASE II.—A gentleman, thirty-three years of age, who had been suffering from hydrocele for several years, and who had been tapped by Dr. Skene, his family physician, came into the hospital September 21, 1892, to get a radical cure. Assisted by Dr. W. H.



Skene and the internes of the hospital, I operated September 22nd. After etherization, I thrust a long knife into the sac, from below, and then cut again from above, evacuating the fluid as the incision was made complete. Two large pieces of the enlarged tunica vaginalis were excised; the testicle was found quite normal, though smaller than usual under the circumstances; the wound was dressed aseptically, and very slight inflammatory disturbance followed. On the sixth day I found the tegumentary parts so much contracted as to leave the testicle practically exposed, and held so by adhesions. The next day I performed the following operation; The adhesions were simply torn through, liberating the displaced testicle; the edges of the tegumentary flaps were cut off, so as to afford a fresh surface; then the flaps were brought together with aseptic silk sutures inclosing the testicle; the parts were dressed antiseptically; primary union took place, with very little inflammatory disturbance; the sutures were removed at the end of five days; and the patient left the hospital October 8, 1892, with a radical cure.

CASE III.—G. O., a laborer, nineteen years of age, on May 10, 1892, ran a tack through the middle joint of his left fore-finger. The injury was followed by severe septic inflammation. The result was anchylosis of all the joints of the injured finger. The flexor and extensor tendons had become firmly adherent to their sheaths. The disability was complete. September 28th, the case came under my care, when I amputated the finger, sawing off the distal end of the metarcapal bone obliquely so as to form a shapely hand. As the tissues did not appear to be in a condition favorable for primary union, the wound was packed with aseptic gauze, in order to obtain secondary union. On the second day the wound was dressed, and the digital artery bled so as to require a suture-ligature. The case did well, and the patient was discharged from the hospital on the 10th of October, being referred to the Dispensary for further treatment.

CASE IV.—Mrs. M. J., thirty-three years of age, about August 15, 1892, had the inner side of the left hand caught by a closing door, causing a compound dislocation of the little finger and a fracture of its first bone. The case came to my Clinic, September 28th. There was still septic inflammation of the hand, and the wound was discharging pus. The finger was entirely useless, and there was no way of restoring its function. I amputated it, removing the distal end of the metacarpal bone, so as to give the

patient a presentable hand. I applied the electro-cautery to the entire surface of the wound, and applied an aseptic dressing; the patient went home.

CASE V.—Miss C. T., seventeen years of age, the last week in August, 1892, caught her left hand in machinery, and received a compound fracture of the terminal joint of the left index finger, accompanied by an outward dislocation of the end bone. On September 28th, I exsected the fragments of the head of the middle finger-bone and a thin slice of the base of the end-bone, shortening the index finger about one-half inch. The wound was dressed antiseptically, and the finger and hand were put on a well padded wire splint which was moulded so as to fit and support the index finger in good position. Then the case resembled one of compound fracture. I have found it useful to save a finger with two bones, one of them being longer than a normal finger-bone, by means of union of the fragments of two bones. This case did well, resulting in repair, that afforded only moderate disability and slight deformity.

CASE VI.—E. D., a boy, eight months old, was brought to my Clinic, September 28, 1892, having a large congenital angeioma of the right hand, for the most part on the back of the carpus and metacarpus, the fingers being smaller than those of the other hand. I made a longitudinal incision along the middle of the back of the hand, and removed the larger part of the diseased structure, at the same time leaving the skin. The electro-cautery was applied to the entire surface of the wound, which was packed with aseptic gauze. On the third day, when the dressing was renewed, there was no hæmorrhage. On October 12th, the wound was nearly healed, and the growth was nearly as large as it was before the operation. The mother took the patient from the hospital, and I have been unable to learn the result.

CASE VII.—J. Mc—, a laborer, twenty-four years of age, October 1, 1892, slipped and fell astride the wheel of his truck, and had retention of urine. He came to the hospital the day after the injury, still being unable to pass his water, and had the signs of a severe contusion of the perinæum. Several attempts to pass a catheter failed. On consultation, it was deemed advisable to make perineal section and an external opening of the urethra. After etherization, I found no difficulty in passing a lithotomy staff. I made a median section of the perinæum, and found no wound of

the urethra, which I exposed for nearly two inches. I did not think it best to open the urethra. The blood of the hæmatocele was evacuated and the wound was dressed antiseptically. The case progressed favorably, the surface of the wound presenting healthy granulations in a few days. October 4th, I put in six deep sutures in order to bring the granulating surfaces into apposition. Superficial sutures along the edges of the skin were required to complete the apposition.

Case VIII.—October 3, 1892, a man, thirty-six years of age, was admitted to the hospital, in a state of shock and collapse, from having his "throat cut" with a razor, just above the hyoid bone. The cut extended from the right to the left, beginning just in front of the angle of the lower jaw on the right side and ending on the left side under lobe of the ear. Neither the throat nor the larynx was opened. The hæmorrhage had been profuse, causing very severe shock. About nine o'clock on the evening of his admission to the hospital, I ligated the partly severed facial vein of the left side and the accompanying artery; also the facial artery of the right side, as well as several bleeding points. The wound was dressed open and antiseptically until the following morning. The next morning I put in twelve deep sutures closing the entire wound, to apply the sides of the cut to each other as accurately as possible; ten superficial sutures were put in to adjust the cutaneous edges for the purpose of obtaining primary union. October 14, I removed the deep sutures, and instructed the house-surgeon to take out all the rest the next day. The union was good except at two points: one at the seat of the left submaxillary gland; the other near the right end of the "cut," where there had been some oozing of blood between the flaps.

Case IX.—Mrs. R., housewife, thirty-four years of age, was admitted to the hospital October 3, 1892, for amputation of right breast. One year before, 1891, I amputated the left breast on account of a large sarcoma which was just ready to break down. There was a large growth on each side of the neck above the clavicle, and the right breast was considerably enlarged. This patient had been treated during the intervening year with the bromide of arsenic; the dose had been one-fortieth of a grain, which was doubled from time to time; every two or three weeks the arsenic was omitted; occasionally she had carbonate of lime in ten grain doses with tr. of columbo. The growths on the neck had largely disappeared; the scar of the previous operation

was quite as normal as one that follows the closure of a large wound in healthy tissue; the right breast had diminished in size to some extent. As the patient desired to have it removed, I operated October 4, the day after admission to the hospital. The operation was performed in twenty minutes. The breast was removed by an elliptical incision, the bleeding being averted by pressure made with the fingers of the assistants, and by the application of hæmostatic forceps. Then the entire surface of the wound was irrigated with a 1 to 3,000 solution of mercuric chloride. No ligatures were applied, the sutures being so put in as to prevent hæmorrhage. I use curved needles which are from three to six inches in length; each ligature takes up a layer of tissue from side to side, so that, when it is tied, it brings the surfaces in contact and prevents the blood from escaping from the vessels. One of these needles is put under or through the end of any bleeding artery, which can, in this way, be completely ligated. I have not used a ligature in an amputation of the breast for many years. This manner of closing the wound does away with the need of a drainage tube, which is certainly a very important advantage.

Case X.—H. S., a groceryman, twenty-five years of age, was admitted to the hospital September 18, 1892. He had severe arthritis of the left knee; it was treated in the usual way until October 5th, when I put a drainage tube through the knee-joint under the tendo-patellæ, in the following manner: A long narrow bladed knife was pushed through the joint, at the place indicated, from side to side; a pair of forceps seized the point of the knife and followed it as it was withdrawn; the forceps then grasped the end of a drainage tube and pulled it through the joint; the joint was then irrigated with a 1 to 5,000 solution of mercuric chloride; the irrigation was repeated every two or three days, and the tube was removed October 13th.

Case XI.—A schoolboy, eleven years of age, was admitted to the hospital August 15, 1892, for disease of the right hip-joint, from which he had suffered since he was three years old. The thigh was adducted and flexed, as well as inrotated; there was a sinus in front, going down to the location of the joint; pus was burrowing in the soft parts of the hip; the upper end of the femur had formed a bony union with the acetabulum. October 5th, I performed the following operation: A free incision was made externally down to the great trochanter, letting out considerable pus; about one inch and a half of upper end of

the femur was cut off with the saw, bone-forceps, and chisel; the pieces were chiseled out of the acetabulum; then limb could be reduced to a position nearly resembling the normal; all the sinuses were "laid open" with the knife and scissors. Some of the bone was hard like ivory, some was so soft that it could be cut with the knife, and some was in a state of osteoporosis; the head and neck of the femur had for the most part been absorbed. The wound was dressed antiseptically, and a long fenestrated splint was applied.

CASE XII.—R. L., a girl, four years of age, was brought to my clinic, October 5, 1892, having a vascular growth about as large as the end of her little finger, on her face just above and near the left angle of the mouth. It had grown up from a small nævus during the three or four months before I saw her. I transfixed the base of the growth with a silk ligature, and tied it in two parts. My little patient declined to take an anæsthetic, and shed two or three large tears, not making any outcry during the operation. The growth came away in a few days, and a cure resulted.

CASE XIII.—R. T., an engineer, thirty-eight years of age, injured the end of the middle finger of his left hand, in some machinery, and about three weeks after came to the hospital for treatment. A sharp piece of the end bone was projecting from the wound, which was delayed in healing. I separated the soft parts from the bony projection, which I cut off with a pair of bone-nippers. The wound healed up in a few days. This patient did not take an anæsthetic.

CASE XIV.—October 9, 1892, a woman, about fifty years of age, was severely kicked by her husband, and was conveyed to the hospital, where I found her suffering from shock. She had a considerable hæmatocele in the left inguinal region, in the location of an inguinal hernia. She gave the history of having had a hernia at the seat of the injury. She had great pain and tenderness. Assume that she had only a hæmatocele, and there would be no objection to cutting down and evacuating the blood; but if she had a hernia complicating the injury, an explorative operation would be imperative. The patient being put under ether, I opened the cavity of the hæmatocele and removed the blood, which was, for the most part, coagulated. There was no appearance of hernia. The wound was made antiseptic, and healed by granulation in about two weeks.

CASE XV.—Mrs. T., forty-five years of age, was seen by me, for the purpose of removing a tumor from the left scapula. I found the tumor was a sarcoma, and advised her friends to take her to the hospital, in order that she might receive constant attention. I told her friends that it might be necessary to remove the entire upper limb, as well as the scapula. On the 13th of October, 1892, assisted by Drs. Lewis, Cochran, Rogers, Rae, and the House Staff, I exsected the left scapula; Drs. Lewis and Rae compressed the subclavian artery. I made an incision from the outer end of the clavicle downward to the lower angle of the scapula; then I made another incision from the same point over the clavicle backward and downward until it reached the lower end of the first incision; these flaps were dissected up until the borders of the scapula were exposed well up toward its neck; the outer end of the clavicle was then severed with a pair of bone-cutters, not far from the acromion; the lower portions of the scapula were then cut from the ribs, with which they had formed strong adhesions; the acromion was seized with the lion forceps, and forcibly elevated so as to sever the posterior part of the capsule of the shoulder-joint, the arm being drawn forcibly forward; the entire axillary border of the scapula was detached with a pair of scissors, when the rest of the capsule of the shoulder-joint was cut through; the attachments of the soft parts to the coracoid process were severed, partly with the scissors and partly with the knife: finally the entire scapula was enucleated by cutting through connections its upper border made with the subjacent structures. The time occupied in the exsection proper was thirty-one minutes.

CASE XVI.—M. T. K., a clerk, fifty years of age, had stricture of the urethra. October 18, 1892, being unable to "pass his water;" an attempt to use the catheter having failed, he was brought to the College Hospital; he passed considerable blood; it was impossible to pass any instrument into the bladder through the urethra. Then aspiration was performed by Drs. Rogers and Swayze. The patient passed a comfortable night; but the retention continued the next day until about four o'clock in the afternoon, when he passed a considerable quantity of water. He said he felt all right and left the hospital.

CASE XVII.—G. L. F., a boy, sixteen months of age, had a congenital nævus on his right cheek; it was about three-fourths of an inch in diameter. After the administration of chloroform, I made an incision around the nævus with the electro-cautery knife down to its deeper portions, and then ligated what was left by trans-

fixion. This little patient had serious chloroform narcosis. The treatment was elevation of the body; artificial respiration; hypodermic injection of whiskey; inhalation of nitrite of amyl. It was about twenty minutes before satisfactory recovery took place. The nævus was cured.

CASE XVIII.—Mrs. A. F., thirty-four years of age, had a fall August 15, 1892, and injured her right ankle; the fibula was broken about three inches above the joint; the internal malleolus was broken off transversely; the foot was dislocated backward nearly two inches; the soft parts were greatly swollen. Dr. Shepard saw her and instituted correct treatment. But the patient persisted in going about house to attend to domestic duties. About the middle of October her doctor brought her to the College Hospital for advice and treatment. She was put under the influence of ether; a sand-bag was placed under her heel; then I sat down upon the front of her leg; at the same time I took hold of the anterior part of her foot, and used the foot as a lever to break up the adhesions; the pressure upon the leg and the manipulations of the foot enabled me to reduce the foot nearly to its normal position and remove the deformity of the fibula to a considerable extent. The result was better than I could have obtained by means of a cutting operation. I put the foot and leg upon my modification of Dupuytren's splint for Pott's fracture. The case turned out well, giving the patient a useful limb with moderate deformity.

CASE XIX.—H. B., a janitor, forty-three years of age, having a moderate-sized epithelioma of the right side of the lower lip, came to my Clinic, October 19, 1892, and submitted to an operation without anæsthesia. I cut out a V-portion of the lip, including the cancer, with a sharp pair of scissors, the hæmorrhage being controlled by Drs. Swayze and Thomas. The cut edges were brought together by means of four aseptic silk sutures, so put in as to control the flow of blood completely. The mucous edges of the lip were sutured also. In these cases, as a rule, I apply no dressings, no retentive slip of adhesive plaster. Primary union took place.

CASE XX.—Mrs. M. E., forty years of age, had a tumor growing on the back part of the neck for four or five years; it was just to the left of the median line and the upper portion of it was close to the skull. Its general appearance was that of a fibro-lipoma. The growth was about three inches in diameter, and appeared to be firmly attached to the surrounding structures. The hair was cut off, and the field of operation made aseptic. The tumor was

exposed by a longitudinal incision, and had to be dissected out; it had considerable vascular connections. The operation was quite bloody; the hæmorrhage was controlled by deep silk sutures, which were put in to close the wound, and an aseptic dressing was applied. The wound healed by primary union, and the patient was discharged from the hospital at the end of a week.

Case XXI.—S. W., a clockmaker, forty-two years of age, was suffering from irritable and painful sphincter ani and serious hæmorrhoids; he came to my Clinic, October 19, 1892, for operation. After anæsthesia, I divulsed the sphincter with my thumbs and fingers, and then ligated the hæmorrhoids by transfixion with a curved needle and double ligature. One row of ligatures encircled the anal orifice; the other row was applied within the anus. Then the ligated hæmorrhoids were incised with the points of a sharp pair of scissors, in order to surely bring about their complete destruction. This patient made a good recovery in about two weeks.

Case XXII.—A. B. W., a carpenter, twenty-two years of age, came, October 19, 1892, after having suffered eight days from inflammation of the palm of the right hand, and requested an operation for relief. Fluctuation and the presence of pus were detected. He said he would try to have the operation performed without an anæsthetic. I made two incisions; one between the tendons of the index and middle fingers, the other between the tendons of the ring and little fingers; pus flowed freely from the first incision. The operation was very painful. This patient left the Clinic and did not return.

Case XXIII.—Mr. C., a car driver, twenty-seven years of age, had a large sebaceous cyst in the left occipital region. No anæsthetic was administered. The hair was cut closely, and the part made aseptic. An incision was made down to the sac from side to side, so as to separate the super-imposed tissue from the outer surface of the wall of the sac;then with an aneurismal needle I enucleated the entire sac without breaking it. In some cases it is impossible to remove the cyst without rupturing it. After this operation the patient needs very little attention.

Case XXIV.—M. N., a school boy, six years of age, had a considerable swelling in the left inguinal region; it was first seen by his mother about six weeks ago; he came to the College, Octo-

ber 26, 1892. The evidence excluded other affections and indicated the existence of hydrocele of the cord; the swelling was tense and firm, though somewhat movable; there was no impulse on coughing; and reduction was impossible. The sac was exposed, and found to contain such fluid as exists in a hydrocele; this was shown by means of an exploring needle. The sac was opened, and the fluid evacuated. The wound was left open in order that it might heal by granulation. The patient made an excellent recovery in about two weeks.

Case XXV.—J. R., a barber, twenty-nine years of age, two years previous, fell down seventeen steps of stairs, and abscesses and fistulæ followed in the ischio-rectal and gluteal regions. I operated upon them at that time. November 2, 1892, he returned, having a fistula on the right side extending downward to a point between the upper part of the coccyx and the ischium; I opened the tract as extensively as possible, causing free hæmorrhage. Then I used the thermo-cautery freely, and packed the wound with aseptic gauze. This patient has posterior curvature of the spine—angular curvature, perhaps due to tuberculosis.

Case XXVI—J. R., a school boy, twelve years of age, was boxing and fell upon his right elbow, breaking off the external condyle. When seen by the doctor, the forearm was dislocated backward and outward; the reduction was easily accomplished. The case was treated subsequently by another doctor, who employed a right-angled splint. Four weeks after the accident the boy was brought to my Clinic, having on a posterior splint, with the forearm extended about twenty degrees beyond a right-angle with the arm; in this position the forearm was slightly movable. After the right-angled splint had been removed, the forearm became fixed in the above-noted position. Any attempt to move the forearm toward a right-angled position caused much pain. I operated as follows: I stood behind the patient so as to prevent him from moving or getting away; then I took hold of the hand and the forearm and forcibly brought the latter up to a right-angle with the arm; the force used was very considerable, and the adhesions were felt and heard "giving way." The limb was put upon a right-angled splint. In this place I will make the following statement: In some instances after fracture of the condyloid end of the humerus, I have seen the forearm have a constant tendency to become more or less extended; in other instances, I have seen the forearm have quite as constant a tendency toward flexion even beyond a right-angle.

Case XXVII.—J. McK., a laborer, about sixty years of age, came to my College Clinic, November 2, 1892, having a swelling of the right side of the scrotum. The diagnosis of hydrocele was made, because the swelling fluctuated and was translucent. It was a small hydrocele, and did not cause much inconvenience. I tapped it with an exploring needle, and slowly "drew off" about two ounces of straw-colored fluid. It is safer at times to use an exploring needle than a trochar and cannula; when there is a small quantity of fluid, the trochar might easily wound the testicle.

Case XXVIII.—L. C., a school boy, ten years of age, came to my Clinic, November 9, 1892, having bony anchylosis of the right knee, the leg was nearly at a right-angle with the thigh, and was outrotated; the knee-pan was absent, having been removed the previous year; the femur, in the lower third, had a considerable curve forward; and the soft parts over the anchylosed joint were not in good condition, having been bruised by a recent fall. The disability was very great; the patient had to use crutches. The case required amputation or exsection; an artificial limb would be required after amputation of the thigh, and then there would be much disability; exsection of the knee might leave the patient with a very useful limb. I made an anterior flap, exposing the lower end of the femur and the upper end of the tibia Then I sawed through the bone, and pushed the lower end of the femur forward; I cut off with exsection saw about two and one-half inches of this bone, leaving the surface convex; the next step was to saw through the upper end of the tibia, so as to leave the cut surface concave; the convex surface of the lower end of the femur fitted into the concave surface of the upper end of the tibia. A drill perforated the anterior part of the upper end of the tibia upward and backward, so that its point came out near the centre of the lower end of the femur: a wire nail was then driven through the hole and made to penetrate some distance into the cancellous bone of the femur; this was to prevent lateral displacement. Finally the limb was laid on an angular splint which kept it moderately bent at the knee—that is, the seat of operation. The bend in the lower end of the femur had to be taken into account; so the angle at the junction of the tibia and femur was made somewhat less than usual. A drainage tube is important in such a case. The dressings were removed on the third day after the operation, also on the sixth day, and the parts were in excellent condition.

Case XXIX.—A. H., a sailor, fifty-five years of age, had contracted sphincter ani, accompanied by hæmorrhoids. At first he

declined to take an anæsthetic; but after the transfixion of one pile with the needle, he requested me to put him to sleep; ether was administered. Then the sphincter was stretched, and the piles were ligated in the usual way.

Case XXX.—F. R., a builder, forty-five years of age, was admitted to the hospital about November 18, 1892, for malignant disease of the abdomen the case seemed to be favorable for exploration with the trochar and cannula. Four or five weeks before admission to the hospital, the patient was seen by Dr. Riggs, who aspirated the bladder four or five times for retention of urine, and drew off large quantities of urine. The abdomen was tympanitic on both sides, and was dull and fluctuating in front. High up on the right side there was considerable submural hardness. The opinion of those who saw the case was that explorative tapping would be proper. A small trochar and cannula were used; and when the instrument had penetrated more than half its length, a dark fluid containing dark flocculent matter oozed out. The trochar was removed and the patient carried to his bed. In the mean time the left lower limb had been greatly swollen, accompanied by considerable discoloration. This patient died in a few days. Dr. Van Cott made an autopsy, disclosing extensive cancerous disease of the abdominal organs.

Case XXXI.—Dr. R., a physician, thirty-seven years of age, had a large variocele on the left side; it had been developing for fifteen or twenty years. He suffered from despondency from time to time. He had been troubled with eczema of the scrotum. The operation was performed November 12, 1892. The varicose veins were exposed and separated from the artery and the vas deferens. A cat-gut ligature was put around the mass of veins just above the testicle, also one was put around it about three inches higher, the intervening portion was excised. The stumps were sutured end to end with fine cat-gut, a drainage tube was inserted, the scrotum was brought together with silk sutures, two of which were passed through the venous stumps in order to reinforce the structure, which would act as a kind of a suspensory ligament for the testicle. There was but slight swelling of the scrotum after the operation The drainage tube was removed November 18th. The patient continued despondent, and was very nervous; the peculiarities of the patient were in part derived from hereditary tendencies. This patient made a good recovery.

Case XXXII.—J. R., a laborer, forty-two years of age, fell November 12, 1892 and struck his head against the edge of the curb-stone.

He was conveyed to the College Hospital, where an examination disclosed a compound fracture of left side of the vertex of the skull. The line of fracture was nearly straight, being about four inches in length. At a point near the middle of this line, it was found that some of the bone had been depressed. There were no signs of compression of the brain; slight evidence of concussion and laceration of the brain was present; the patient could walk and talk and give a good account of the accident. On consultation with my colleagues, it was decided to operate the next morning, November 13, 1892. The operation was performed as follows: The wound was enlarged slightly in front; the flaps, for such they were, were drawn aside by retractors; at the central part of the fracture I cut away the bone on the right side with a sharp chisel and mallet, and picked out two spicula of bone which had lacerated the dura; then I had to cut out more bone to make an opening large enough to remove a rough piece of the inner table of the skull about an inch and one half in length; a considerable clot was found and broken up and washed out with an antiseptic solution; a drainage tube was introduced, and the flaps were stitched together. This patient made a good recovery.

Case XXXIII.—T. H., a boy, three years of age, and somewhat under the normal size, had the usual symptoms of stone in the bladder; at times a slight click could be made out with the searcher, as if there was an encysted stone or a very small one. The urethra was very small, and would admit only a No. 6 staff. I operated November 16th before the medical class, with my hospital colleagues present. The knife was held in the median position until it entered the grove of the staff, when it was lateralized to the left and made to increase the size of the cut as it was withdrawn. It was then pushed along the groove of the staff far enough to partly sever the fibres of the neck of the bladder; a grooved director was then passed into the bladder, when I pushed my forefinger between the director and the staff until the end of it felt the stone; the staff was removed and the lithotomy forceps introduced but the stone was not grasped, then the scoop brought out a stone about one-half inch in diameter. The bladder was washed out with a warm carbolic solution, and the patient was put to bed.

Case XXXIV.—Mrs. M. M., twenty-six years of age, about two years previous to her admission to the College Hospital had an abscess on the outside of the right thigh. A fistula extending from the knee to a point near the hip had been left. The patient had

been treated in another hospital for about five months. After the administration of ether, I introduced a long grooved director into fistula, and laid it completely open by means of a pair of angular scissors. The ill-conditioned layer of granulations was scraped off the surface as completely as possible. The wound was wiped out with towels saturated with a 1 to 2000 solution of mercuric chloride, and an antiseptic dressing applied.

Case XXXV.—W. W., a clerk, twenty-one years old, had an exostosis on the inner aspect of the neck of the first left metatarsal bone: it was about an inch and a half in diameter, and had been growing from childhood. The right radius was much deformed, causing some disability. The skin on the summit of the growth was not in a condition to be saved. Two longitudinal flaps were dissected from the upper and lower sides of the projecting bone, and the tumor was partly cut off with a Hay's saw; the bone-cutter completed the severance. The flaps were brought together with silk sutures.

Case XXXVI.—A. B., a sailor, forty years of age, came to the hospital, November 15, 1892, having a swelling on the right side of the neck over the middle part of the sterno-cleido-mastoid muscle. It had been about four weeks forming; it had a point of less resistance and there was some evidence of the existence of a wall of "limiting fibrin." The patient suggested that the swelling might have a specific origin. Without an anæsthetic I cut it open and found some ill conditioned pus and considerable necrotic matter. The hæmorrhage was slight. The dressing was antiseptic. The treatment was tonic and anti-syphilitic. The recovery was speedy.

Case XXXVII.—H. D., a farmer, fifty-one years of age, came to the hospital, November 9, 1892, suffering from pains in the branches of the left great sciatic nerve; medical treatment for nine days did not benefit him. In the spring of the same year his left foot had been wounded by the tooth of a harrow while he was at work in the field. The scar was somewhat hard and painful on pressure. On November 18th, I exsected this scar; it was located over the heads of the first and and second metatarsal bones. Deep sutures were introduced and primary union followed. The patient left the hospital, November 23d, improved, and I have not seen or heard from him since.

CASE XXXVIII.—J. C., a Norwegian sailor, had inflammation of the bursa in front of the right patella. I operated for radical cure, November 21, 1892. A vertical incision was made into the bursa; the fluid and the "rice-like" bodies were evacuated; the adventitious bands were excised, the entire surface of the cavity was scraped with a bone scoop. Deep sutures, six in number, were put in so as to make complete closure of the bursa, and the edges of the cut surface were brought together with superficial sutures. The deep sutures were tied over a compress made of aseptic gauze. On the ninth day the stitches were all removed; at that time complete union had taken place. The deep sutures pass under the fibrous tissue in front of the patella, and require considerable care and skill in their introduction.

CASE XXXIX.—R. F., a German sailor, thirty-eight years of age, was suffering from synovitis of the left knee-joint, and came to the hospital for treatment. The case had been about four weeks developing. After making the field of operation thoroughly aseptic I passed a long narrow bistoury through the joint just back of the tendo-patellæ and in front of the femoral condyles. A long pair of catch forceps followed the knife as it was withdrawn, and then seized a drainage tube which was drawn through the joint. The joint was then irrigated with a 1-3000 solution of mercuric chloride, the accumulated fluid being thoroughly washed out. Antiseptic dressings were applied. At the end of four days the drainage tube was removed.

CASE XL.—Second operation in Case XXIX, A. H., fifty-five years of age, had two piles that did not become completely strangulated, and so did not slough off. Ether was administered, and the piles were removed with electro-cautery knife. The larger one of the two was supplied by a large hæmorrhoidal artery, nearly as large as the radial. A suture ligature had to be applied before the hæmorrhage ceased. This patient did very well, and was so far recovered that he left the hospital in about two weeks.

CASE XLI.—Eva S., three years of age, had congenital equino-varus of the left foot, with marked deformity. I severed the tendo-Achillis by inserting the knife back of the tendon and cutting forward. Firm pressure on the bottom of the foot separated the ends of the tendon fragments over an inch. Then I cut the plantar fascia which had contracted and caused nearly right angled flexion of the foot. The knife was inserted below the fascial band, which was severed by cutting upward. Using considerable force I crushed the

foot nearly into a straight position. The foot and leg were firmly bandaged to a well-padded splint, fashioned after my modification of Dupuytren's splint for the treatment of Pott's fracture. The operation was performed, November 30. December 3rd, I removed the splint and reapplied it. The case was progressing favorably.

CASE XLII.—Mary C., one year old, had a nævus at the root of the nose just above a line between the eyes. It was of considerable size and very vascular. Several injections of alcohol had failed to cure it. I cut out nævus with the electro-cautery knife. A large artery supplied blood to the growth at its lower part. I applied a suture-ligature which controlled the hæmorrhage and put in another suture, closing up the wound almost completely. There was no hæmorrhage except at the seat of the arterial supply mentioned. This case did well, and there was only a small scar left.

CASE XLIII.—W. D., five months old, had a small and very vascular nævus over the region of the anterior fontanelle. An effort to cure it with injections of alcohol failed. I made an incision around it with the electro-cautery knife, and then, raising it up with forceps, sutured its basal connections. There was no hæmorrhage during the operation. Just enough tissue was removed to encroach slightly on the normal structure. The wound was dressed antiseptically. The result was favorable, only an insignificant scar being left.

CASE XLIV.—J. F., about sixty years of age, five years ago had an operation for radical cure of hydrocele of the left side. The operation was by free incision, inflammation and granulation. The result was very perfect. On November 30, 1892, I operated for radical cure of hydrocele on the right side. The field of operation was made aseptic; a long, narrow bistoury was pushed through the bottom of the sac; it was then pushed out again about four inches higher up; a long pair of catch forceps followed the knife as it was withdrawn; a drainage tube was then seized and pulled through the cavity of the tunica vaginalis; a 1-4000 solution of mercuric chloride now washed out this cavity, and the drainage tube was fastened in, after which an aseptic dressing was applied. This case made a good recovery.

CASE XLV.—Mrs. C., about forty years of age, five weeks ago wounded her right hand over the metacarpo-phalangeal joint of the index finger, while opening a can of lobster. Septic inflammation followed,

and resulted in necrosis of the first finger bone and destruction of the joint at its base. November 30, I made oval flaps and sawed distal end of the metacarpal bone off obliquely, in order to improve the shape and the utility of the hand. The entire surface of the wound of operation was seared with the electro-cautery knife, for the purpose of disinfection. The open dressing was applied. On December 4th, the wound was healing, and the appearance of the hand had improved.

Case XLVI.—C. C., a three-year-old boy, had phymosis, with adhesion of the prepuce to the glans, and accompanied by irritability and nervousness. The prepuce was not contracted, but adherent. The usual dorsal incision was made with the sharp point of a curved bistoury and with a pair of scissors. The adhesions were very firm, and required much force to separate the prepuce from the glans. The end-portion of the prepuce was cut off all around with a pair of scissors. A fine catgut suture began at the angle of the incision on the back of the neck and went continuously around the cut edge until it arrived at the point of outset, where it was tied with the other end of it. Two important objects are gained by this suture: The mucous and cutaneous edges are quickly brought together; the suture is absorbed and does not require to be removed by the surgeon. This case did well.

Case XLVII.—December 1, 1892, Wm. S., fourteen years of age, had his right hand drawn into a press; the metacarpus and the carpus were crushed; the hand was torn from the forearm at the wrist-joint. The operation was performed about four hours after the accident. The forearm was extended and the anterior flap was made by transfixion; the forearm was pronated, and the posterior flap was made by incision. The radius and ulna were sawed off from before backward, and the last stroke of the saw severed both bones at the same instant. The ulnar nerve was drawn out a little more than two inches and cut off, and then the ulnar artery was ligated. The radial nerve was drawn out and about two inches of it cut off. The radial artery was found under the integument in an abnormal position and tied; the amputation was made near the middle of the forearm and the flaps were left longer than ordinary. The interosseous vessels were secured by a suture ligature; the needle was passed close to the outside of the ulna in one direction and returned in the opposite direction close to the inside of the radius, and then the ends of the ligature were tied; the hæmorrhage ceased. The sub-tegumentary portions of the

flaps were brought together over the cut ends of the bones by means of a continuous suture of catgut, and then a drainage tube was passed through with a pair of catch forceps. The stump was dressed in the usual way. December 5th, the drainage tube was removed, and another was inserted; the one removed contained a clot of blood, making it completely impervious.

Case XLVIII.—J. M. F., twenty years of age, had an ischio-rectal abscess in May, 1892, and came to the hospital, and was operated on, December 2, 1892, by Dr. Rogers, for a fistula which extended into the rectum. The cavity of the fistula was opened and thoroughly scraped and scarified. The case made a rapid recovery.

Case XLIX.—Mr. B., sixty years of age, was admitted to the hospital December 1, 1892, with an opening in front of the patella from an abscess which began about three weeks previous. An exploration showed that the knee-joint was not involved. The abscess cavity was very extensive. Counter openings were made in five different places around the knee, and as many drainage tubes were inserted. This patient improved rapidly and soon left the hospital nearly cured.

Case L.—A very muscular policeman, forty-five years of age, fell into the hold of a vessel and struck on his left shoulder, December 2, 1892, when he was brought to the College Hospital. He had a sub-clavicular dislocation of the left humerus. There was a severe contusion on the outer aspect of the left arm just below the acromion, showing that this was the part upon which he struck. After complete etherization, it required one of my assistants and the house surgeon to make the reduction by pulling on the limb downward, backward and outward. The patient was discharged from the hospital at the end of a week much improved.

Case LI.—A. P., a seaman, twenty-two years of age, November 29, 1892, fell and broke an earthen jug, a sharp piece of which made a lacerated wound of left elbow at the seat of the ulnar nerve. He came to the hospital on the 5th of December, with loss of sensation and very slight voluntary motion of the right ring and little fingers. On the 8th, I cut down upon the ulnar nerve where it passes the internal condyle, and found it bruised and nearly torn in two parts. I exsected the injured portion, about one inch in length, and sutured the ends with catgut, closing the wound so as to permit good drainage, and placing the limb on a nearly

straight anterior splint. There was some improvement. After several weeks he left the hospital, with partial recovery.

Case LII.—J. S., three years of age, fell and struck the left side of his head, and when he was brought to the hospital he had a hæmatocele covering about one-half the surface of injured side of the head, and showing some signs of fracture of the skull. On December 8, 1892, I made an explorative incision, large enough to admit my finger, and found the skull denuded of periosteum for about one-half the extent of the hæmatocele, but there was no fracture. After thorough evacuation of the blood, I put on an aseptic compress and did not remove it until the lapse of a week, when primary union of the surfaces of the entire cavity had taken place, leaving only the wound of exploration.

Case LIII.—K. D., a seaman, twenty-one years of age, in a low state of health, had an ischio-rectal abscess four weeks before admission to the hospital, December 6, 1892; it had opened spontaneously, and presented an unhealthy cavity; the fistula extended to the mucous membrane of the rectum. On the 9th of December, Dr. Cochran operated in the usual way, laying open the fistula and scarifying the unhealthy tissue of its wall. Under tonics, rest, nutrients, and asepsis, the patient began to improve.

Case LIV.—J. C., seventeen years of age, had been developing a painful swelling in the right iliac region for four or five weeks; during this time I had seen him twice, and advised an operation. He came into the hospital December 8, 1892, and I operated the next day. The diagnosis was that of pelvic abscess. He had no difficulty with his bowels, and the abscess was circumscribed. Aspiration failed to bring out any matter. Then I made an incision about three inches in length over the centre of the swelling, beginning just below the superior anterior spine of the ilium and going downward and inward, nearly parallel with its inner anterior border. There was considerable hæmorrhage; and there came from the abscess cavity some blood, some pus, and considerable necrosed tissue. My finger went down between the sub-peritoneal fascia and wing of the ilium. The peritoneal cavity was intact, and the vermiform appendix was not involved. Antiseptic irrigation made the abscess cavity surgically clean. There was no elevation of temperature, and the patient made a rapid recovery. I have operated on several cases like this one. They are very interesting, and it is important to make a correct diagnosis.

Case LV.—James McS., seventy-two years of age, came into the hospital December 13, 1892, and was operated on the same day. Ten years previous I operated on his lower lip for cancer, and the disease did not recur until the lapse of about four years. On the day of his return the entire border of his lower lip had grown up for some distance with epithelium which projected in a ragged fringe; about one-half inch of the border of the lip had become infected. I did not think it expedient to give him an anæsthetic; nor did I think it would be safe to perform a long plastic operation. He lay down upon the table; I passed a strong silk suture just outside of and just below the angles of the mouth, to have control of the flaps; my assistants and the house surgeons were ready to control the hemorrhage; then, with a pair of curved scissors, I cut off the diseased border of the lower lip, by means of curved incision sutures; doubled up the cut edges, brought the two edges together and permanently arrested the hæmorrhage; then his mouth was made out of his upper lip, and was not at all sightly. In about one week, union had taken place, and the house surgeon removed the sutures. On the 24th of December, the upper lip had been drawn around on both sides so as to make the under lip nearly as long as what was left of the upper one.

Case LVI.—T. L., thirty-five years of age, in the habit of drinking, and occasionally having an epileptic fit, fell some distance and struck on the left foot about the first of November, 1892, severely injuring the left ankle. The diagnosis was fracture of the astragalus, fracture of the internal malleolus, with backward and inward dislocation of the foot. The swelling was excessive, accompanied by a marked tendency to mortification and the formation of extensive blebs. The parts were put into a wire-trough splint in order that the swelling might subside. Alcoholic delirium came on in a short time, and Dr. Rogers put on a splint of plaster-of-Paris to keep the limb from further injury. The soft parts over the lower end of the fibula sloughed, and the displacements could not be removed. December 13th, about five weeks after the accident, I exsected the lower end of the fibula, the lower end of the tibia, and the upper half of the astragalus, using the osteotome and mallet, as well as the lion-forceps. Then the foot could be reduced so as to make its relations with the leg nearly normal. Improvement was slow, but eventually the patient recovered with a useful limb.

CASE LVII.—May N., seven years of age, with tubercular disease of lower end of the left fibula, was etherized, December 15, 1892, and the inflamed tissues were opened longitudinally with the electro-cautery knife, which was also used in making several adjacent punctures. The parts were dressed with iodoform and antiseptic gauze. This patient was much improved by rest, tonics and nutritious food. The local disease was for the most part arrested. Subsequently a small tubercular ulcer over the ankle was scraped out and cauterized with the galvano-cautery.

CASE LVIII.—C. H., thirty-five years of age, December 16, 1892, was struck on the back of the head about midway between occipital protuberances and the mastoid process with a "sling shot," and soon after was brought into the hospital. He was suffering from concussion of the brain and shock. In the wound there could be felt an indentation of the bone. The hair was shaved off, and the skin was disinfected. The fracture was superficial, and trephining was not necessary. Primary union of the soft parts occurred, and the patient made a speedy recovery. Since the advent of antispetic surgery, explorative operations of the head can be performed without danger. The present practice is very different from the practice of years ago.

CASE LIX.—Captain C. had a chronic hydrocele of the left side of the scrotum. It had been tapped from time to time for about ten years. He desired a radical cure. I passed a drainage tube through the scrotum, that is, into and out of the tunica vaginalis, evacuated the fluid, and washed out the cavity with a 1-5000 solution of mercuric chloride, and applied antiseptic dressings. He did not take an anæsthetic; he said there was only slight pain. At the end of a week, the tube having been drawn upward by the contraction of the scrotum, I put in another from the lower puncture to another one lower down. This patient left the hospital, January 1, 1893, in excellent condition, having a radical cure. He came to the hospital, December 13, 1892. Some time after leaving the hospital, an adventitious sac developed on the same side. I opened it, and there is no further trouble likely to arise.

CASE LX.—J. E. W. had an ischio-rectal fistula, following an abscess that had occurred a year ago. I operated on December 16, 1892, in the usual way, opening the fistula and scarifying the surface, so as to get a new granulating surface. He made a very rapid recovery, going out of the hospital in about ten days.

Case LXI.—M. K., a lawyer, thirty-two years of age, had a compound fracture of the forefinger and middle finger of the left hand. The point of special interest in this case was an attempt to suture the tendons into the flaps after amputation through the continuity of the first bones of the fingers. The finger stumps have no tendons to move them. They are practically in the way. I have often had patients beg to have such stumps removed that had been carefully saved under the rules of conservative surgery. The rule is save all you can of a finger—all that you can make useful.

Case LXII.—J. W., a laborer, twenty years of age, had suffered for some years with an ingrowing nail of the left great toe. Under ether, the entire nail was removed by incision and avulsion. The diseased parts were cauterized with the electro-cautery knife. The relief was immediate, and the recovery was speedy. When a toe-nail is so diseased that it becomes a foreign body, it is better to removed, and save your patient both time and annoyance. The nail must be thoroughly removed, or it may grow again and cause trouble.

Case LXIII.—J. B., a machinist, thirty-eight years of age, had been disabled by hæmorrhoids for several months, and came to obtain relief. An operation was performed, December 21, 1892. The hæmorrhoids were seized with forceps, and then cut off with the electro-cautery knife. There was slight after-hæmorrhage, which was controlled by the further use of the electro-cautery. The patient made a rapid recovery. The usual operation performed by me is ligation. It is not my purpose to condemn anyone's operation, yet I incline to advise against injecting piles for the purpose of curing them.

Case LXIV.—W. R., aged fifteen years, had a lacerated wound of the right hand, caused by a sharp piece of glass penetrating it at the bifurcation of the ulnar artery. December 26, 1892, I applied suture-ligatures at the seat of the injury. The secondary hæmorrhage returned on the second day after. The ulnar nerve was implicated, and further operation in the wound did not seem to be advisable. On December 28, 1892, I ligated the brachial artery in the middle third. Subsequently there were two or three times when considerable hæmorrhage occurred at the seat of the injury. Then the radial pulse was good, but I could not detect any pulsation in the ulnar artery above the wrist. This patient was pale

and not well nourished; he seemed to be prone to hæmorrhage. His recovery was slow, and the ulnar nerve did not fully regain its functions. The seat of the wound was sensitive and tender.

CASE LXV.—C. G., a married woman, twenty-two years of age, December 28, 1892, was shot in the left breast and the upper part of the left thigh. Dr. Rae removed the ball from the soft parts over the ribs on the left side. The wound did not penetrate the thoracic cavity. The wound on the front of the thigh was about two and one-half inches below Poupart's ligament. I made an exploratory incision, and found that the ball had passed just external to the femoral artery on its way upward and backward. It did not seem practicable to continue the exploration. The disinfection was made as perfect as possible, and the wound was dressed aseptically. Septic fever developed, and it was not controlled by medication. January 9, 1893, the inner aspect of the thigh was opened, and a considerable quantity of sero-purulent fluid oozed out. The patient died January 13, 1893.

CASE LXVI.—J. S, an engineer, thirty-nine years of age, had a compound fracture of the end bone of the right thumb. Operation, December 29, 1892. It was possible to disarticulate the end-bone, and cover the distal end of the second bone with good flaps, thus carrying out the rule to save as much of the thumb as possible for an opponent to the fingers.

CASE LXVII.—B. K., work-girl, eighteen years of age, had suffered for some months with obscure pains in the abdomen. I saw her with her family physician, Dr. McManus, and confirmed his diagnosis of appendicitis. As her surroundings were very unfavorable, we had her taken to the College Hospital for operation. The prognosis was very bad. I operated December 30, 1892, performing laparotomy along the right side of the rectus muscle. I came down upon an abscess, partly saculated, partly diffuse, with the folds of intestine extensively adherent to each other and to the abdominal wall, the pus having found its way into the peritoneal cavity. The pus was evacuated as far as possible, and then all the parts were irrigated with a warmer aseptic fluid. The drainage was made as good as the circumstances would permit; and the patient was sustained by such means as are appropriate in such cases. After the operation the shock continued. She seemed to suffer in spite of all that could be done for her, not so much from pain, as from an indefinable and severe distress. It

was a case of diffuse suppurative appendicitis, in which general sepsis had taken place, probably from the pus finding its way into the peritoneal cavity. Expectant treatment would have ended in death; the operation did not reach any better result. Yet it seems to be best to operate on such cases. If the abscess had not been diffuse an operation would have been more likely to bring relief.

Case LXVIII.—K. K., a four-year-old girl, January 18, 1893, was playing on the floor with some other children, when a pistol, they had in their possession, went off, shooting her in the left side. She was brought to the College Hospital, where an examination showed that there was a penetrating wound of both the chest and the abdomen. An incision at the seat of entrance of the ball showed that the seventh rib had been perforated. I excised about an inch and a half of the rib where it had been perforated, and found that the ball had passed through the edge of the left lung, and then gone on through the diaphragm into the abdomen. There was, on exploration of the abdominal cavity, no evidence of any wound of the viscera, there being no blood to remove. It appeared as if the ball had largely spent its force in perforating the rib, and that it had become quite harmless on entering the abdominal cavity. The air passed in and out the opening during respiration. The intercostal arteries bled freely, but the hæmorrhage was controlled by catch-forceps. A drainage tube was put into the abdominal cavity, and another into the lung; the external ends of both were stitched to the integument. The drainage tubes were removed January 14, 1893. The abdominal wound closed in a short time, but the wound in the lung did not heal completely for a number of weeks. The patient finally recovered and was taken from the hospital in good condition.

Case LXIX.—R. E., a laborer, thirty-five years of age, came to the hospital January 2, 1893, having fallen and received a wound of the face and forehead; he had a depressed fracture at base of the skull on the right side just posterior to the orbit. An exploratory incision showed only an indentation of the outer table of the skull. The wound was closed and repaired by primary union. The patient left the hospital in a few days in good condition.

Case LXX.—O. H., a sailor, twenty-seven years of age, broke his left patella transversely, and was treated in the ordinary way, recovering with fibrous union. About the middle of December, 1892, he fell and refractured his patella, and came into the College

Hospital with his knee much swollen from extravasated blood. I had his knee bandaged in the figure-of-8 fashion, and put his limb upon my patella-splint. I operated on his patella January 4, 1893. Over the centre of the patella a longitudinal incision was made long enough to permit sawing off the broken ends of the fragments. The fragments were drilled through, the lower one from below, upward and backward; the upper one from above, downward and backward; the wire—after being inserted—came just in front of the condyloid groove of the femur; the cut surfaces of bone were accurately adjusted; the wire was twisted in front; a drainage tube was passed through the flaps on either side; the flaps were sutured over the "united" fragments, and the dressings were applied; then the limb was placed upon my patella splint. The next day I removed the drainage tube, and reapplied the dressing. On the 15th of January everything was going on favorably. January 16th the sutures were removed and there is good motion of the knee-joint.

In about six weeks this patient was discharged from the hospital in good condition. He went out on the icy streets a few days after that, and fell, breaking his patella nearly in the same place as before. He returned to the hospital, and I operated again. The fractured surfaces only required careful scraping to make them fit well. The wire suture was still in, but had become brittle from twisting it, and from pulling on it at the time of refracture. I put in a new wire, and got primary union of the soft parts as well as speedy union of the fragments.

Case LXXI.—J. McD., a sailor, thirty-two years of age, came into the hospital January 4, 1893, with a large inguinal hernia of the right side tightly strangulated. The hernia was irreducible, and of long standing. An immediate operation was necessary. The usual incision was made over the neck of the sac, which was opened. Even then the hernia was irreducible. Upon examination the sac contained the caput coli and the appendix, which was nearly four inches in length and unusually large. A considerable part of the ileum accompanied the caput coli. The appendix had a mesentery, which was removed after ligation. The appendix was amputated; silk sutures were used to invaginate the serous membrane. The adhesions of the contents of the sac were dissected through, and then the reduction could not be made. And the reduction was only accomplished after cutting the abdominal wall upward about two inches, and having the foot of the table elevated materially. Then the stump of the appendix presented

at the opening. The hernial sac and the structures of the spermatic cord were interwoven in inextricable confusion, so I brought down the sac and ligated it at the neck including the structures of the cord. Profuse hæmorrhage soon occurred, and it was found to come from the cord, which was seized and a ligature applied. The incision in the abdominal wall was closed with strong silk sutures after aseptic irrigation. This did well in every respect. I removed the sutures on the 15th of January. They had "cut in" to a considerable extent. On the 16th of January the patient got out of bed and went to the "water closet." Then he kept in bed for several days, and the tissue in the wound became firmer from day to day. In a little time he was allowed to get up and go about the ward, and finally left the hospital with a radical cure.

Case LXXII.—G. G., a laborer, thirty-five years of age, had painful stumps of the second, third and fourth toes of the left foot. The ends of the stumps projected upward, and were pressed upon by the boot. Dr. Cochran and the house surgeon operated, disarticulating the toe-stumps. The wound was completely closed, and primary union followed.

Case LXXIII.—H. M., a girl eleven years of age, while at play, fell upon her left hand, and was brought to the hospital by her father. She had a "bent fracture" of both bones of the left forearm. The lower ends of the radius and ulna were bent backward nearly forty-five degrees. The lower radial fragment was about seven-eighths of an inch in length. The lower ulnar fragment was about five-eighths of an inch in length. I made the reduction by putting my thumbs upon the angle of displacement, and applied my fingers against the dorsal aspect of the parts above and below, and then using considerable force. There was some crepitus when the bones were straightened. The parts were put in a trough-splint made of wire cloth.

Case LXXIV.—M. D., a colored girl, four years of age, had triple displacement of the left leg from tubercular disease of the knee-joint. On January 11, 1893, I exsected the knee, and found the femoral condyles containing suppurating cavities. The lower end of the femur was cut off, as well as the upper end of the tibia. The cut ends were adjusted and nailed together. The limb was put on double inclined plane, having a large obtuse angle, in order that the limb might be slightly bent when the bones were united. On the evening of the day of operation, the patient pulled and kicked the dressings nearly off, so that they had

to be readjusted. This operation was completed in twenty minutes. It took nearly three months to obtain bony union of the femur and tibia.

CASE LXXV.—J. R., a laborer, twenty-three years of age, had his right leg amputated at the knee-joint for osteo-sarcoma of the leg. The operation was performed at my Clinic of last year. He came into the hospital for the removal of a sarcomatous growth from the back part of his thigh about four inches above the end of the stump. I operated January 11, 1893. The enucleation of the growth from the nerve, artery and muscles was easy enough. The wound was packed with aseptic gauze. The patient was given the bromide of arsenic in one-fortieth grain doses three times a day. At the time of the previous operation the bromide of arsenic was given. When he had improved materially, he refused to take the remedy, and after that he did not do as well. He did not keep up the treatment. In May, 1893, I saw this patient, and he had a large, rapidly growing osteo-sarcoma of the sacrum.

CASE LXXVI.—Wm. W., forty years of age, was operated upon at last year's Clinic for an abscess of the left mastoid process. The operation was incision and linear-osteotomy. A fistula had been left. He returned for another operation. A free incision was made, and the scar was scarified. This patient left the hospital the next day, and has not been heard of since.

CASE LXXVII.—C. L., a laborer, twenty-four years of age, while "tying up" bags in a factory, November 23, 1892, cut the little finger of his left hand, and suffered from septic inflammation which resulted in necrosis and anchylosis. The finger was amputated, leaving the head of the metacarpal bone. The wound was closed completely. There was primary union, giving a good result. The operation was performed on the 12th of January, 1893.

CASE LXXVIII.—J. W., a nine-year-old schoolboy, was run over by a truck January 16, 1893, and had the leg and the knee of the right side crushed, and also had a compound, comminuted fracture of the left thigh in the middle third. He was brought to the College Hospital in a state of extreme shock. I made a rapid amputation of the right thigh in the lower third, as low down as possible, and, after ligation of the arteries and excision of the sciatic nerve, a deep, continuous suture was applied so as to pre-

vent oozing. The left thigh and its wound were disinfected, and a long, straight splint applied on the outside. No traction was used, for the other side would only have a stump, and the repair would no doubt be speedier than under an attempt to remove the shortening. The operation added to the shock, which continued for three days. This patient did not get out of bed for nearly six weeks. The left limb shortened; how much is unknown.

Case LXXIX.—J. C., a fireman on a tug, thirty-two years of age, had his left foot burned from falling between the boiler and the side of the boat; and, after some weeks, the fifth metatarsal bone and the bones of little toe suffered from necrosis. On the 18th of January, 1893, I removed the dead bones, and then the repair was rapidly completed, leaving the man a useful foot. The rule in such cases is: Do not operate until the furrow of separation between the living and dead parts is well established. I have often applied this rule to advantage in cases of frost-bite, as well as those of burn.

Case LXXX.—H. B., a sixteen-months-old girl, had a tumor on the back over right scapula. It had been noticed about four weeks by the mother. On removal it was found to be a vascular cyst, resembling a cystic sarcoma. The hæmorrhage was profuse, but was arrested by means of suture-ligatures and packing the operation-wound with aseptic gauze. The growth began to recur, but the new tissue went away after the administration of bromide of arsenic, in one-hundredth grain doses.

Case LXXXI.—J. S., sailor, forty years of age, had a compound comminuted fracture of the bones of the right middle-finger, followed by necrosis and total disability of the injured finger, which was in the way of the other fingers. On January 20, 1893, the finger was disarticulated by the oval method. The operation wound was packed with aseptic gauze, and when granulation took place the flaps were brought together, so that union by "second intention" took place.

Case LXXXII.—H. S., machinist, twenty-eight years of age, caught the ends of the first, second and third fingers of the right hand, between the cog-wheels of moving machinery, and had compound fractures of their end-bones. On the 20th of January,

1893, the base of each one of these end-bones was extended, so as to save the tips of the fingers. The middle finger-bone was made, as it were, longer by so much of the end-bone as was left, and the normal tactile surfaces of the injured fingers were preserved, making the patient a more useful hand than he would have had with an amputation.

CASE LXXXIII.—T. S., a lad, thirteen years of age, Jan. 20, 1893, had fallen from a height, and struck on his right foot, driving the astragalus upward so as to produce a vertical posture of the lower end of the tibia. The ankle was enlarged, and the foot was everted, there being a fracture of the fibula, about three inches from its lower end. After anæsthesia, I succeeded in removing much of the deformity by means of forcible manipulation. The parts were kept in place by means of my modification of Dupuytren's splint. The result was very good, there being slight disability of the ankle left.

CASE LXXXIV.—C. D., an intoxicated man, fifty-three years of age, for the purpose of drawing off his water, took a hat-pin six inches in length, and pushed the glass head of it through his urethra into the bladder, its sharp point being lost in the pendulous part of the penis. On the 24th of Jan., 1893, the day after the accident, I saw the patient, and found the point of the hat-pin lodged in the soft part, just at the anterior limit of the scrotum, the head of the pin being in the bladder. I made every preparation for a cutting operation. Then I pushed the skin so as to make the point of the pin protrude, when I seized it with a pair of forceps and pulled the pin out, so as to bring the head of it into the urethra, under the place where it emerged, and then reversing the direction by carrying its point downward and backward, it was easy enough to push the pin's head out of the meatus, and so pull the entire pin out. Then the patient went home—"all right."

CASE LXXXV.—Mrs. M. D., twenty-six years of age, had a fracture of the left leg just above the ankle, twenty years ago. In the meantime there had been occasions when she had suppurating sinuses at the seat of injury. She had a considerable enlargement over the front of the lower end of the tibia, on which I operated Jan. 25, 1893. A vertical incision was made down to and into the bone, the saw being required for cutting the bone, and then the

growth was partly sliced out with the scalpel. The wound was dressed open, and the patient was given the bromide of arsenic, 1-40 gr. after each meal. The rest of the growth disappeared in a few weeks, and an apparently perfect recovery followed.

CASE LXXXVI.—A man about seventy-five years of age, in feeble health, came to my clinic, Jan. 25, 1893, having a large hydrocele of the left side of the scrotum. He did not seem to be strong enough to have a radical cure undertaken, so he was tapped and the fluid drawn off with trocar and cannula.

CASE LXXXVII.—A nine-year-old school boy had tubercular disease of the foot. An incision was made into the infected parts including the diseased bones. The infected parts were scraped out as far as possible, and the excavations were well washed out with a 1 to 1,000 warm solution of mercuric chloride. Drainage tubes were inserted, and antiseptic dressings were applied. The carbonate of lime was given the patient before meals, and the syrup of the iodide of iron was given after meals. The progress of this case was very favorable.

CASE LXXXVIII.—Captain B., seventy-three years of age, had an ulcerating epithelioma upon his right cheek, and was too feeble to take an anæsthetic. He lay down upon the operating table, and the electro-cautery knife was used to cut a circular furrow around the neoplasm, which had a surface a little larger than the thumb-nail. Then the mass was ligated, as thoroughly as possible, by passing a strong ligature under its base in several directions. It sloughed away in a few days, and he left the hospital much improved, with the surface of the excavation granulating. He returned some weeks later exhibiting a nearly normal scar.

CASE LXXXIX.—A laborer, thirty years of age, came to the clinic, with a sebaceous cyst, having a very thick wall on the back of the head. It was adherent to the peri-cystic tissue, and had to be dissected out. There was considerable hæmorrhage, requiring the use of the suture-ligature, which is best inserted by a curved Hagedorn's needle. Sebaceous cysts of the scalp can generally be easily enucleated.

CASE XC.—T. M., a girl, eighteen years of age, had an abscess of right axilla. The abscess was opened, and irrigated with a warm solution of mercuric chloride. The healing was rapid and satisfactory.

CASE XCI.—This was the same patient as Case XXIV. New foci of pus-formation were found in the tissues adjacent to the incisions made previously. They were thoroughly opened. Then the patient was treated with ten-grain doses of carbonate of lime given three times a day. No other pus foci have been developed, and the patient has been recovering in a very satisfactory manner. Operation performed Feb. 1, 1893.

CASE XCII.—On the same day, Mr. D., thirty-three years of age, had the little finger of his right hand amputated for incurable deformity caused by a burn. The head of the fifth metacarpal bone was cut off obliquely, in order that the hand might have a better shape. The flaps were brought together with deep sutures, and primary union was obtained.

CASE XCIII.—J. M., farmer, thirty years of age, on evening of Feb. 8, 1893, had his left foot crushed by the wheel of a trolley car, and was brought to the College Hospital. On consultation it was found that the foot could not be saved. The day after the accident I amputated the leg in the middle third. The posterior flap was made by transfixion, and the anterior by incision. The anterior tibial artery was secured by a suture-ligature. The two principal nerves were drawn out and cut off as closely as possible. The general health of this patient was not good, and the soft parts were bruised. Repair went on slowly.

CASE XCIV.—T. B., a woman, about fifty years of age, was admitted to the hospital Feb. 17, 1893, suffering from cancer of the liver, accompanied by dropsy. A large quantity of fluid was drawn off by tapping, and then the disease of the liver could be surely traced. Such cases are hopeless. We know of nothing that will save the life of such a patient. Our appeal is, let physicians never cease to make every attempt to find some medicine that will give our patients relief. It is to be hoped that a cure for cancer will some day be found.

Case XCV.—Mrs. M., forty-nine years of age, had a femoral hernia of the left side, which had caused her more or less trouble fifteen years. The hernia became strangulated, and could not be reduced. After the lapse of three days, and when several attempts at reduction had failed she was brought to the College Hospital on the evening of Feb. 15, 1893. I operated just before midnight, and found a very tight constriction biting the intestine, which had a small loop protruding. The intestine appeared to be almost gangrenous. It was adherent to the entire sac, which had to be dissected off. The patient was in such a collapse that a very speedy operation was required. The opening was made large enough to place the damaged part of the intestine just within the abdomen. An exsection would have been fatal, for the patient barely survived the operation under the circumstances. It was thought that if sloughing of the intestine occurred, it would be well to have the wound left open. So the parts were dressed in such a way as to permit a free drainage. It was three days before this patient showed any material signs of reaction. She slowly improved after this time. The wound healed by granulation, making a firm scar. The patient went home at the end of about five weeks, and will have a radical cure.

Case XCVI.—H. B., twenty-four years of age, had a compound fracture of the end-bone of the right index finger, caused by a circular saw. A circular flap amputation was made at the middle of the second finger bone. There was primary union.

Case XCVII.—F. L., seventeen years of age, had an ingrowing nail of the right great toe. It acted as a foreign body, and the "flesh" had grown up over each side of it. The nail was split with a pair of scissors and the parts everted, and then the fleshy granulations were cut off.

Case XCVIII.—T. S., a ship's mate, fifty years of age, on Feb. 3, 1893, had an attack of vomiting, and then he noticed a swelling in the right groin, just below Poupart's ligament. He was brought to the hospital, where an exploratory operation was advised. It was not easy to say how much of the swellling was hernia, how much was adenitis, how much was abscess. Hence, it was thought best to make an exploration. After anæsthesia, an incision was made down to the sac which was very thick. The end of a foreign body presented itself to the touch of the finger, and on removal it was found to be a wood-sliver about two inches in length, sharp at either end and generally somewhat rough of surface. It

was a sliver of hard pine wood. It had worked its way from the intestine out through its wall and the wall of the hernial sac. The parts were freely opened to let out the pus, and afford good drainage. Repair took place in the wound, and after two weeks the bowels were moved by injections and laxatives. In about three months the patient was sent home to England. His general condition, while not very good, had improved. At no time did it seem advisable to undertake further operation. At the time I operated upon him, an exsection of the intestines would have caused his death, on account of his feebleness. In the future it may be deemed advisable to operate further.

Case XCIX.—T. R., an Italian sailor, came to my clinic, Feb. 27, 1893, having tubercular infection of the glands of the neck. An incision was made into them, and they were thoroughly scraped out with the curette. In such cases, the bronchial glands in the upper part of the chest are involved, and cannot be removed. An operation for the removal of tubercular gland of the neck is more or less serious. And it often happens that some foci of infection cannot be reached safely; but the process of repair more frequently removes the peri-glandular bacilli, and the cases do remarkably well. Having this experience, I am not so anxious as formerly to remove all suspected points.

Case C.—J. C., a driver, twenty-two years of age had periostitis of the left tibia. An incision was made down to the bone, allowing free hæmorrhage. Then linear osteotomy was performed, so as to permit the escape of inflammatory products from the bone. The wound was dressed open, and the case improved for a time; then pus formed in the tissues adjacent to place of the operation. The administration of the carbonate of lime arrested the work of the pus-organisms.

Case CI.—H. W., three years of age, had symptoms of stone in his bladder. A sound confirmed the diagnosis. On March 1, 1893, I performed the medio-lateral operation. The stone was an inch in length, half an inch in thickness, and five-eighths of an inch in width. One of its sides was attached to the mucous membrane of the roof of the bladder, and detachment was necessary before I could grasp the stone with the forceps. While the right hand pushed backward and downward the abdomen over the bladder, the left index finger detached the stone. Here I must repeat the advice: To pass a grooved director through the wound into

the bladder, before the removal of the staff, in order to guide the finger safely into the bladder between the two instruments, thus preventing the possibility of pushing the neck of the bladder away from its connections with the deep fascia. This case made an excellent recovery.

Case CII.—A colored man, only sixty years of age, was admitted for an operation; removal of the left breast which had developed a small cancer about as large as the fist. The disease had been about two years developing. Cancer of the male breast is rare. There was nothing very special in the case, except that there was not integument enough to close up the wound of operation. The tumor was small and circumscribed. Much care was taken to make this case successful; but in a few days after the operation, pneumonia "set in" and the patient died in forty-eight hours.

Case CIII.—Mr. F., twenty-one years of age, had the end of his right thumb crushed by machinery, and after bruised portions mortified, they were trimmed off, so as to leave as much of the thumb as possible, a small part being left to granulate. The result was a useful thumb.

Case CIV.—C. P., a boy fourteen years of age, March 3, 1893, was accidentally shot, just internal to the left eye, the ball going through the left nasal bone, and into the cells of the ethmoid bone, where it was decided to leave it after a careful exploration. There were no special symptoms developed. The patient made a rapid recovery. The ball, which was fired by a small pistol, became encysted.

Case CV.—J. S., a laborer, forty-five years of age, in a fit of despondency, because he had failed to get work and earn bread for his family, cut his throat. The wound opened the larynx, but did not sever the large blood-vessels of the neck. The wound in the larynx was closed with cat-gut sutures. The wound of the neck external to the larynx was closed by deeply inserted sutures, and a drainage tube was employed. The wound had been injected while the patient was waiting to be conveyed to the hospital, and so there was some suppuration. The patient made a good recovery.

Case CVI.—J. F., a laborer, thirty-eight years of age, July 3, 1892, had a strangulated hernia of right side, accompanied by dropsy, and was operated for its relief by Dr. Lewis. It was not possible to make a radical cure at that time, and the wound was

left open so as to permit the fluid to run off from the peritoneal cavity. He returned in March 1893, having a recurrence of the hernia. An operation was undertaken for radical cure. The spermatic cord was very short, and could not be well separated from the tissues around it. I pushed it firmly to the inner side of the opening and fastened it here with cat-gut sutures, and closed up the vaginal canal. The result was very encouraging, but after a time there was a recurrence of the protrusion in the meshes, so to speak, of the spermatic cord. He was very anxious to have a cure so that he could continue his work of a stone-mason. He gave permission to remove the testicle, if it were found necessary. In operating the next time, I found on exposing it, his testicle very small, with the epididymis nearly gone, and the cord was so involved in its surroundings that it could not be separated to any extent, nor was there any sac that could be dissected up. The cord was ligated on a level with the internal ring, and the testicle was removed. The stump of the cord was fastened in situ, and the ring was completely closed with cat-gut sutures. Then the wound was closed with deep silk sutures. The repair was by primary union, and the condition good. He left the hospital the last of April, having a radical cure.

Case CVII.—B. F., a workwoman, had a painful and ulcerating stump of the right leg, which had been amputated in the middle third, twenty-six years before, when she was twelve years old. A re-amputation gave her an excellent stump covered with integument. There was a kind of fatty condition of the stump, the adipose tissues being abundant, and the bones being quite soft. She can now have an artificial limb applied, and be able to lay aside her crutch.

Case CVIII.—Same as Case XXXIII. Adventitious cavities containing pus were opened as freely as possible. The administration of ten-grain doses of carbonate of lime arrested the extension of the infection and the patient recovered.

Case CIX.—T. H. B., a sailor, forty-six years of age, had some indolent swelllings in the upper part of the front of the left thigh. They had opened and discharged, leaving sinuses. Ether was given, the sinuses were opened and the cavities were irrigated with a solution of mercuric chloride. Under a tonic and alterative treatment, this patient slowly recovered.